SURGICAL & PROCEDURAL BLOCK REQUEST

DATE: _____

REQUESTOR: _____ _____

Physician or Group Name *Contact Name and Phone Number*

Facility: ☐ Bend ☐ Redmond Unit: ☐ OR ☐ MDU ☐ CATH LAB

1. Check One:

☐ I am requesting New or Additional block time.

Rank your top three choices for assigned day of the week (1 being firstchoice):

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY

Number of blocks per Month:

Anticipated # Cases Per Block Day: Average Duration (wheels in/out):

Anticipated % of inpatient admission: Ratio of adult to pediatric cases:

Please indicate your specialty and most common procedure(s) performed:

☐ I am requesting a change to my block time. Describe in Question 2

☐ I am relinquishing (forfeiting) my assigned block. List the day(s) relinquished in Question 2

☐ I am requesting that all or a portion of my block be excluded from the 7 day automatic release. Describe the release exclusion you are seeking in Question 2.

2. Additional Comments:

3. Return completed form via e-mail to: blockrequests@stcharleshealthcare.org

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MEETING SCHEDULES & PROCESSING TIMELINES

The Bend/Redmond Block Committee meets the 3rd THURSDAY of each month. Decisions are generally communicated within the week following the meeting.

REQUEST DISPOSITION *(For Committee Use Only)*

☐ Approved Assigned Day(s): Room*:

☐ Denied Decision Date: Effective Date:

Committee Comments:

*Actual room location may vary to accommodate daily operational resource needs.